Chapter Overview/Summary

Understanding and appropriately treating psychological disorders depends, in large part on the adequacy of clinical assessment. The assessment process typically involves interviews, observations, and psychological tests that are then integrated to develop a summary of the client’s symptoms and problems. Assessment results are frequently used to establish a baseline of client behavior from which subsequent behavior can be judged in the process of clinical diagnosis—that is, classifying a disorder according to a clearly defined system such as the DSM-5 or the ICD-10 (International Classification of Disease). Even after this initial assessment and diagnosis, continued assessment is critical to determine the course and effectiveness of treatment procedures. Psychological assessment uses tests, observations, and interviews. Clinical diagnosis is when the clinician arrives at a disorder based on the most recent edition of the DSM, the DSM-5.

There are several basic elements of clinical assessment. Identification of the presenting problem or the major symptoms and behavior is most likely the first step in the assessment process. Providing a diagnosis may assist in treatment planning and may be required for insurance purposes. Clinically, assessment will most likely involve collecting information about the client’s behavioral history, intellectual functioning, personality characteristics, and environmental pressures and resources. The precise nature of the information collected will, of course, depend on the nature of the presenting problem. Because a wide range of factors may contribute to maladaptive behavior, assessment may also include medical evaluation.

A general medical examination may be followed by a more comprehensive neurological examination that could involve neuropsychological testing or, in some circumstances, neurological tests—such as an EEG or a CAT, PET, or MRI scan—to aid in determining the site and extent of organic brain disorder. The precise nature of tests administered during this assessment process may be influenced by the theoretical orientation of the clinician. For example, a more biologically oriented clinician may be more apt to focus on assessment procedures aimed at determining underlying organic malfunctioning, while a more cognitively oriented clinician may focus on dysfunctional thoughts.

In order for any assessment procedure to be effective, however, the client must feel comfortable with the clinician. The clinician should explain the purpose of the assessment process and must help the client understand the limits of confidentiality.

Psychosocial assessment methods focus on providing a realistic picture of how the client interacts with his or her social environment. Data is gathered, allowing the clinician to form hypotheses that are confirmed, modified, or discarded as the clinician proceeds. The most widely used and most flexible psychosocial assessment methods are the clinical interview and behavior observation. These methods provide a wealth of clinical information and can vary from highly structured and reliable procedures to more unstructured and less reliable procedures.

Psychological tests represent a more indirect method of assessing psychological characteristics. The tests used by psychologists compare the client’s responses to standardized stimuli with the responses of other people with similar demographic characteristics, usually through established test norms or test score distributions. For all psychological tests, the competence of the person administering, scoring, and interpreting the test will dictate their value. This issue becomes even more important when computerized administration, scoring, and interpretation of psychological tests have become widespread.

Psychological tests can be divided into two major categories: intelligence tests and personality tests. The most common intelligence tests are the individually administered Wechsler scales (WISC-III and WAIS-III) and the Stanford Binet Intelligence Scale. Personality tests can be subdivided into two additional categories based on their approach: 1) projective tests, such as the Rorschach, in which unstructured stimuli are presented to a subject who then “projects” meaning or structure on to the stimulus, thereby revealing “hidden” motives, feelings, and so on; and (2) objective tests, or personality inventories, in which a subject is required to read and respond to itemized statements or questions.
Objective personality tests, such as the MMPI-2 and MMPI-A, provide a cost-effective, reliable, and valid means of collecting a great deal of personality information rapidly. Assessment also allows clinicians to engage in classification, which aids in communication, research, gathering statistics, and meeting the needs of insurance companies. Classification, however, is a constantly evolving process that is subject to human error.

All classification systems depend on reliability and validity. Currently, there are three basic classification systems used in abnormal psychology: the categorical (adopted for use in the DSM-5), the dimensional, and the prototypal. The categorical system has been questioned in recent years, as the categories do not always result in within-class homogeneity or between-class discrimination. This, in turn, can lead to high levels of comorbidity among disorders. Several possible solutions to this problem include dimensionalizing the phenomena of mental disorder and the adoption of a prototypal approach to the organization of the field. For all of its problems, however, knowledge of the DSM-5 is essential to serious study in the field of abnormal behavior.

There are two major classification systems used today. One, the ICD-10, is used widely in Europe. The DSM-5 is used in the United States. Both systems are similar in that they focus on symptoms and define problems into different facets. In the DSM-5, for example, behavior can be diagnosed along five axes. The present DSM is the result of a long process that began with the publication of the first DSM in 1952. The first two DSMs were more narrative and jargon-laden. With the publication of the DSM-III and DSM-IV-TR, a radically new approach was introduced. Operational definitions were adopted requiring a specific number of signs or symptoms from a designated list prior to diagnosis. This allowed for diagnosis to be more reliable and valid than in previous years, especially with the introduction of structured clinical interviews. The DSM-5 was published in 2013 and has been the most controversial alternation to diagnostic thinking to date as it has incorporated more theoretical shifts. Although the DSM system is standard in the United States, there are many who do not like providing any diagnosis for a client. One of the major objections to any such diagnostic classification is the problem of labeling. In the final analysis, any such classification should only be seen as a first step, subject to revision, in the overall process of understanding and treating abnormality.

Detailed Outline

I. The Basic Elements in Assessment
   A. Psychological assessment—refers to a procedure by which clinicians use tests, observations, and interviews
   B. Clinical diagnosis—the process by which the clinician arrives at an diagnosis
   C. Presenting problem—major symptoms or behaviors the client is experiencing
   D. The Relationship Between Assessment and Diagnosis
      1. Formal diagnoses are needed for insurance purposes
      2. Planning for treatment follows from diagnosis
      3. It is essential for administrative purposes
   E. Taking a Social or Behavioral History
      1. Personality factors
         a. Descriptions of long-term personality characteristics are included.
         b. How has the person responded to different situations?
      2. The social context
         a. Environmental stressors and supports are identified.
         b. Conflicting information is integrated, leading to understanding of what may drive the person (what some call a dynamic formulation).
         c. Hypotheses about future behavior are derived.
         d. Decisions about treatment are made with consent of the client.
         e. Coordination of physical, psychological, and environmental procedures is needed in assessment,
   F. Ensuring Culturally Sensitive Assessment Procedures
      1. Cultural competence issues in both clinical and court-related multicultural assessments are important when dealing with culturally diverse populations.
      2. APA recommends psychologists consider things like language and differences in cultural situations when looking at test scores.
G. The Influence of Professional Orientation
1. Psychiatrists are biologically oriented practitioners.
2. Psychoanalytically oriented clinicians may use unstructured assessment methods.
3. Behaviorally oriented clinicians determine the functional relationships between environmental events, consequences, and behaviors.
4. Cognitively oriented clinicians focus on dysfunctional thoughts.
5. Humanistically oriented clinicians may use interview techniques to uncover blocked or distorted personal growth.
6. Interpersonally oriented clinicians may use behavioral observations to identify problematic relationships.

H. Reliability, Validity, and Standardization
1. Reliability is a term describing the degree of consistency in a measurement.
2. Validity is the extent to which a measurement measures what it purports to measure.
3. Standardization is the process by which a psychological test is administered, scored, and interpreted in a standard way.
4. T score distribution is the distribution of scores.

I. Trust and Rapport Between the Clinician and the Client
1. Clients should understand the underlying rationale of assessment.
2. Assurances of confidentiality.
3. Motivation of client for being assessed.
4. Importance of providing feedback to client.

II. Assessment of the Physical Organism
A. The General Physical Examination
1. A medical history is obtained.
2. This medical exam is needed when presenting problems include physical symptoms, especially when clients may be experiencing somatoform, addictive, or organic brain disorders.
3. Such medical exams may eliminate costly and ineffective treatments.

A. The Neurological Examination
1. Electroencephalogram (EEG) to assess brain wave patterns in awake and sleeping states, which reveals dysrhythmia.
2. Anatomical brain scans
   a. Computerized axial tomography (CAT scan) can reveal diseased parts of the brain. Technique involves computer analysis of x-rays.
   b. Magnetic resonance imaging (MRI) allows visualization of the interior of the brain. Images are typically much sharper with the MRI, and the MRI is less complicated to administer and does not expose the client to ionizing radiation. Only major problem is that some clients have a claustrophobic reaction.
3. PET scans: A metabolic portrait
   c. Positron emission tomography (PET scan) appraises how an organ is functioning rather than simply the anatomical structure like those above. PET scans work by tracking natural compounds such as glucose as they are metabolized. Unfortunately, the pictures produced are of low-fidelity and the equipment is fairly expensive.
4. The functional MRI (fMRI) measures changes in local oxygenation of specific areas of brain tissue allowing a “map” of brain activity to be developed. This technique may lead to more detailed information of how psychological disorders develop but at this time, there are significant problems with the procedure.
   d. Aphasia—a disorder in which there is a loss of ability to communicate verbally.

B. The Neuropsychological Examination
1. Measurement of alteration in behavioral or psychological functioning involves neuropsychological assessment.
2. Neuropsychologists may administer a standard test battery or, more frequently, administer a highly individualized array of tests depending on the particular client’s problems.
3. The two most common test batteries are the Halstead-Reitan and the Luria-Nebraska.
4. **Halstead Category Test** measures a subject’s ability to learn and remember material.
5. **Tactual Performance Test** measures a subject’s motor speed.
6. **Rhythm Test** measures attention and sustained concentration through an auditory perception task.
7. **Speech Sounds Perception Test** determines whether an individual can identify spoken words.
8. **Finger Oscillation Task** measures the speed at which an individual can press a level with the index finger.

III. **Psychosocial Assessment**

A. **Assessment Interviews**
   1. Structured and unstructured interviews
      a. Structured formats have been developed to guide questions
      b. **Structured assessment interview** yields far more reliable results than the flexible format
      c. **Unstructured assessment interview** is typically subjective and does not follow a predetermined set of questions
      d. **Rating scales** help focus inquiry and quantify the interview data
      e. Reliability increases with structured interviews
      f. All interviews need specific goals
      g. Rating scales can increase interview reliability
      h. Interviews are subject to error as they rely on human judgment
      i. Emphasis on observable criteria

B. **The Clinical Observation of Behavior**
   1. Direct observation
      a. Should occur ideally in the natural environment
      b. Analogue or contrived situations are designed to yield information about the person’s adaptive strategies
      c. **Role-playing**—the event reenactment, family interaction assignments or a think-aloud procedures
      d. **Self-monitoring** or self-observations and objective reporting of behavior are often used in the natural environment, can also be used in determining the kinds of situations in which maladaptive behavior is likely evoked.
      e. The client can be an excellent source of information.
      f. Methods such as electronic beepers to remind clients to record thoughts are also being developed.
   2. Rating scales
      a. Help to organize observations and increase reliability
      b. Ratings may be made not only as part of an initial evaluation but also to check on the course or outcome of treatment.
      c. The **Brief Psychiatric Ratings Scale (BPRS)** is widely used to record observations for clinical research.
      d. Comparisons to other clients’ symptoms can be made.

C. **Psychological Tests**
   1. Psychological tests are standardized procedures to sample behavior
      a. A client’s responses are compared to the responses of others who have taken the same test
      b. Often more precise and reliable than interviews or some observational techniques
      c. Many tests are available in a computer-administered and computer-interpreted format
      d. Their value depends on the competence of the clinician administering them
   2. The value of the test frequently depends on the competence of the tester Intelligence tests
      a. Wechsler Intelligence Scale for Children-Revised (WISC-IV)
      b. Stanford-Binet Intelligence Scale
      c. Wechsler Adult Intelligence Scales-Revised (WAIS-IV)
d. These tests are used when detailed information about cognitive functioning is required

3. **Intelligence tests**—widely used to measure intelligence abilities in children and adults
   a. **Vocabulary (verbal)**—subtest that consists of a list of words to define that are presented orally to the individual
   b. **Digi Span (performance)**—test of short-term memory a sequence of numbers is administered orally.

4. **Projective personality tests**
   a. Underlying assumption in using projective techniques is that people “project” their own problems, motives and wishes onto the vague, unstructured stimuli
      (1) The **Rorschach Inkblot Test**—named after the Swiss psychiatrist Hermann Rorschach as a personality assessment
      (2) The **Thematic Apperception Test (TAT)**—introduced in 1935 by Morgan and Murray of the Harvard Psychological Clinic which uses simple pictures where subject are constructed to make up stories
      (3) **Sentence Completion Test**—these tests have been designed for children, adolescents, and adults which is related to free association where the client is asked freely based on the answers the examiners can pinpoint the individual’s problems, attitudes, and symptoms through the interpretation of his or her responses
   b. Interpretation of these tests is generally subjective, unreliable, and difficult to validate
   c. Administering and scoring these tests is frequently time consuming and requires advanced skills
   d. These tests have an important place particularly in clinical settings where it is important to obtain information about one’s personality and psychodynamic functioning

5. **Objective personality tests**
   a. More structured than projective techniques leading to greater precision, typically use questionnaires, self-report inventories, and rating scales
      (1) **MMPI: The Minnesota Multiphasic Personality Inventory (MMPI)** is the most widely used personality test in the United States (See Table 4.1 for a chart of the scales of the MMPI-2)
      (2) The clinical scales of the MMPI were developed through empirical keying
      (3) Clinical scales measure tendencies to respond in psychologically deviant ways
      (4) Validity scales designed to detect whether a patient has answered the questions in an honest manner
      (5) Special problem scales have also been developed
      (6) Criticisms of the MMPI led to MMPI-2
      (7) Advantages and limitations of objective personality tests
      (8) Advantages include being cost-effective, highly reliable and objective
      (9) Disadvantages include some believing they are too mechanistic to portray the complexity of human behavior and the tests require the client to be literate and cooperative
      (10) Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
      (11) The MMPI-2 has replaced the original MMPI
      (12) The MMPI-2 is used in same way as the original
      (13) Validity scales detect dishonesty and lack of cooperation
      (14) Computer interpretation of objective personality tests
      (15) **Actuarial procedures** used where descriptions of the actual behavior or other established characteristics of many subjects with particular test scores have been stored in the computer
      (16) Difficulty in collecting sufficient actuarial data
      (17) Computer cannot integrate conflicting findings
IV. The Integration of Assessment Data
   A. Integration of assessment data prior to treatment allows the clinician to formulate a plan for treatment and allows for the discovery of gaps or discrepancies in knowledge about the client.
   B. Additional assessment data collected during treatment can allow clinician to determine how effective treatment is and allow for modification to improve success.
   C. The information gathered may lead to a tentative diagnosis.
   D. Ethical Issues in Assessment
      1. Potential cultural bias of the instrument or the clinician
      2. Theoretical orientation of the clinician
      3. Underemphasis on the external situation
      4. Insufficient validation
      5. Inaccurate data or premature evaluation

V. Classifying Abnormal Behavior
   A. Classification allows communication, improves research, and is required by many insurance companies for reimbursement
   B. Classification is important in any science and involves the intent to delineate meaningful subvarieties of maladaptive behavior
   C. Classification systems are ongoing works-in-progress as new knowledge allows more precision
   D. Reliability and validity
   E. Differing Models of Classification
      1. The dimensional approach
      2. The prototypal approach

F. Formal Diagnostic Classification of Mental Disorders
   1. Two major systems in use today are the International Classification of Disease System (ICD-10) used mainly in Europe and the Diagnostic and Statistical Manual of Mental Disorders (DSM) used mainly in the United States.
   2. DSM was designed as a categorical system but is actually a prototypical system.
   3. Symptoms—refers to the patient’s subjective description and the complaints he or she is experiencing
   4. Signs—objective observations that the diagnostician may make either directly or indirectly
   5. The evolution of the DSM
   6. Criteria used consist of symptoms (subjective description of the client) and signs (objective observations)
   7. The DSM has evolved over the past 6 decades from a vague, jargon-laden description of disorders to the present “operational” method. The DSM-5 has been the most controversial alteration to date.
   8. Limitations of the DSM classification system still exist, especially in relation to the artificial, categorical systems adopted
   9. Gender differences in diagnosis/prevalence rates
   10. Appraisal of cultural background in DSM-5
      a. Diverse society and levels of acculturation
      b. Structured interview provided in DSM-5: The Cultural Formulation Interview (CFI)
   11. The problem of labeling. Labeling may lead to a closing off of further inquiry, create preconceptions about a person, or even lead the person to act in ways consistent with his or her view of how a person with that label “should” act
   12. Limited usefulness of diagnosis.
      a. Diagnosis is only the beginning step of a comprehensive evaluation and treatment
   13. Unstructured diagnostic interviews
      a. Allow the examiner to pursue “leads” but reduce reliability
   14. Structured diagnostic interviews
      a. The Structured Clinical Interview for DSM Diagnosis (SCID) and others have substantially improved diagnostic reliability
VI. Unresolved Issues

A. The DSM-5: Issues in Acceptance of Changed Diagnostic Criteria

1. Many argue there are issues with the categorical nature of the DSM as the categories appear to be unable to distinguish between classes of disorders. Thus there is a high comorbidity between disorders.

2. The DSM-5 has been criticized for possible over-diagnosis of bipolar disorder, expansion of ADHD into adulthood, and inclusion of natural grief after the death of a loved one in the diagnosis of depression.

3. The DSM is a constantly evolving work in progress, and even critics agree it is indispensable.

Key Terms

actuarial procedures   positron emission tomography (PET scan)
aphasia               presenting problem
Brief Psychiatric Rating Scale (BPRS)  projective personality tests
clinical diagnosis  psychological assessment
comorbidity          rating scales
computerized axial tomography (CAT) scan reliability
dysrhythmia           role-playing
electroencephalogram (EEG)  Rorschach Inkblot Test
forensic              self-monitoring
functional MRI (fMRI) sentence completion test
intelligence test  signs
magnetic resonance imaging (MRI) standardized
Minnesota Multiphasic Personality Inventory (MMPI) structured assessment interview
neuropsychological assessment  symptoms
objective personality tests T score distribution
personality tests  Thematic Apperception Test (TAT)
self-monitoring  unstructured assessment interviews
sentence completion test  validity